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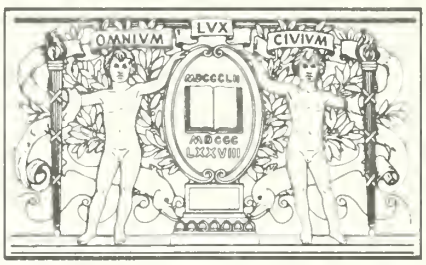

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OPTIONS FOR UNITED WAY FUNDING OF COMMUNITY HEALTH CENTERS

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OPTIONS FOR UNITED WAY FUNDING
OF
COMMUNITY HEALTH CENTERS

United Community Planning Corporation

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OPTIONS FOR UNITED WAY FUNDING OF

COMMUNITY HEALTH CENTERS

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INTRODUCTION

Community Health Centers provide comprehensive, primary medical care in neighborhoods where other sources of care are scarce. There are 39 community health centers in the United Way of Massachusetts Bay service area.

The United Way received a request for affiliation from one health center. United Way support was requested for two programs -- general health and counseling. As a result of this affiliation request, the United Way requested an overview of community health centers which would provide information to assist it in developing a position concerning United Way funding of health centers.

This paper identifies a series of possible roles for the United Way. It describes six financing arrangements and discusses the positive and negative implications for United Way for each option enumerated. The options discussed in Section D are:

1) To provide support to community health centers by funding free care;

2) To provide support for mental health counseling;

3) To provide support for primary health care services;

4) To provide support for preventive health services;

5) To provide no financial support to community health centers; and

6) To provide support to the Massachusetts League of Community Health Centers, an association of health centers across the state.

As an aid in assessing these options, also presented is material describing the role of community health centers in the health care delivery system, the changing funding patterns, the future of health centers, the impact of United Way revenue on other sources of funds, the financial implications for United Way, and a discussion of how some large United Way organizations in other areas relate to community health centers.

It should be noted that, as requested by United Way, no needs assessment for the services offered by community health centers was conducted. The discussion of funding alternatives is thus a generic one; it reaches no conclusions. The options are ranked, however, in terms of UCPC's perceptions. It is assumed throughout this discussion that any actual application for affiliation from a community health center would be analyzed separately, and in depth, as are all applications to United Way. Specific needs assessments could be performed. The adoption of one of the options listed could provide a framework within which each individual application would be reviewed.

A. DEFINITION

Community Health Centers (CHCs) are facilities for ambulatory health care providing comprehensive primary medical care, social services, and a variety of community-based programs. Services provided generally include:

Adult Medicine	Laboratory
Alcohol Treatment	Mental Health
Dental Care	Nutrition
Dermatology	Obstetrics
Eye Care	Pediatrics
Family Planning	Podiatry
Gynecology	Social Services
Home Visits	Speech and Hearing

These services are provided either on-site or through affiliated agencies.

Community health centers are regulated by the Department of Public Health; they may be either independently-licensed or operate under a hospital license. CHCs are non-profit organizations, with an elected, community-based Board of Directors (if independent) or Advisory Board (if hospital-licensed). Independently-licensed CHCs are autonomous; the degree of hospital influence on the operation of a hospital-licensed health center will vary depending on the specific relationship. The following discussion centers on independently-licensed community health centers.

B. BACKGROUND

Columbia Point Health Center, established in 1965, was the first health center in the country. The Department of Health and Hospitals of the City of Boston, with cooperation from the local teaching hospitals, the state, and the Health Planning Council, was instrumental in developing the present system of CHCs in the City of Boston. A Districting Plan for the placement of health centers attempted to ensure that centers were located in areas where access to private, primary care physicians was poor. Most centers in the United Way of Massachusetts Bay area, and all those receiving Section 330 Public Health Service federal funds, are located in federally designated Medically Underserved Areas and Health Manpower Shortage Areas. (See Funding, Section C)

Federal support for health centers began in the 1960's and grew throughout the 1970's, first primarily under the Economic Opportunity Act and now under the Community Health Center Program (Section 330 of the Public Health Service Acts). When it is implemented, the Primary Care Block Grant will include this program. Another major source of original funds was Title V of the Social Security Act (Maternity and Infant Care and Children and Youth Projects), now the Maternal and Child Health Block Grant, and the Model Cities program.

There are currently 39 community health centers in the United Way of Massachusetts Bay Service Area (See Exhibit 1 and accompanying maps). Twenty-seven of these centers are located in Boston.

C. FACTORS FOR CONSIDERATION

1. The Role of Community Health Centers in the Health Care Delivery System

Community health centers are a source of primary health care in neighborhoods which do not have many other health care resources, whether those resources be private physicians, hospital outpatient departments, hospital emergency rooms, health maintenance organizations, or physician group practices. As one interviewee stated, health centers are located where private physicians cannot earn a living.

"Each center is an expression of the neighborhood it serves, reflecting the racial, linguistic, economic and cultural characteristics of its patients." (5)*

Community health centers concentrate on preventive medicine and comprehensive primary care services rather than the episodic treatment one often obtains at a hospital emergency room or outpatient department.

Although initially seen as costly and inefficient, community health centers are now considered a cost-effective means of providing not just ambulatory health care but also as an efficient means of entry into the entire health care system. (3, 9) Not only are centers less expensive than other sites, they are also internally efficient. The independently-licensed centers in Boston experienced only a 1-2% cost increase from 1977 through 1979. (2) In addition, patients who utilize health centers as their major source of care receive fewer hospital days of care per year than others, up to 34% fewer in some cases. (3)

Many centers are part of managed health care programs or health maintenance organizations. Such programs provide care for individuals or families for a set fee per year - a capitation payment - regardless of the volume of services provided that member. Such financial and organizational arrangements have been shown to help control the cost of health care.

Commonwealth Health Care Corporation (CHCC) is proposing to organize such a system of care for all AFDC Medicaid recipients in the city of Boston. The population covered may grow over time. CHCC, currently in the planning stage, is a provider controlled organization - 50% of the Board represents Community Health Centers and 50% represents Boston's teaching hospitals. One goal of CHCC is to change the site of primary care delivery from the more expensive hospital emergency room to the less-expensive ambulatory care setting. Depending upon the results of CHCC's planning efforts, some, or all, community health centers will continue to play a major role in the delivery of primary health care to Medicaid recipients.

* Numbers in parentheses refer to references.

The impact of financing on the organization of the health care system may also be seen as the hospital industry throughout Massachusetts adapts to the passage of Chapter 372 - the hospital reimbursement legislation which became effective October 1, 1982. Under this legislation, hospitals will be reimbursed prospectively; that is, they will know at the start of the fiscal year what their gross operating revenue will be. Prior to this, hospitals were reimbursed on a retrospective cost basis, so that there was little incentive for cost-efficiencies. There is now an incentive for hospitals to treat patients in the least costly manner. Outpatient as opposed to inpatient care may be encouraged. It is too early to tell exactly what will be the impact of this legislation on the utilization of health centers.

2. Utilization

In 1981 there were over 1,100,000 primary care visits to community health centers in the United Way service area, of which over 415,000 were by Medicaid recipients. (See Exhibit 2)

A study of Boston's health centers found that while visits at community health centers have increased 10.5% per year on average between 1976 and 1979, visits at teaching hospital outpatient departments increased only 1.7% on average. The years 1979 to 1981 saw a 23% increase in community health center visits. (9) The Health Planning Council of Greater Boston found that certain cost efficiencies were realized in centers which provided more than 20,000 encounters per year. (2) (An encounter occurs each time a particular service is utilized. For example, if one sees a physician and also has laboratory tests, two encounters have occurred.)

The age breakdown for the 1979 visits was as follows: 36% children, 56% adults, and 9% elderly. (9)

3. Funding Sources[1/]

Exhibit 3 depicts total revenue for the independently-licensed health centers; exhibits 4 to 7 present the components of the revenue of independently-licensed community health centers by center. For the Boston centers information is available for fiscal years 1977, 1979 and 1981. During this time most centers have increased the proportion of their revenue obtained from self-payers and third-party payments while decreasing the proportion of the budget which is obtained from sources which subsidize the care provided to those who cannot pay. Even so, although the range is from 17% to 74%, the average for all health centers is just over 50% subsidized. The aggregate budget for all health centers in the United Way of Massachusetts Bay area is nearly $40,000,000.

a. Subsidy Funds

"It is important to note that the determination of the 'source' of community health center funds is, in part, an artificial one; most of the community health center monies ultimately trace back to the federal government and represent some category of Public Health Service Act funds, or other federal programs. For the purposes of this analysis (and the attached Exhibits), the "source" of funds was assumed to be the entity responsible for the disbursement of those funds directly to the community health center. Therefore, although WIC (Supplemental Food Program for Women, Infant's and Children) funding comes to the state from the federal government, that money is allocated to community health centers by the Department of Public Health and, therefore, is identified as state funds. A few exceptions to this approach should be noted. Community Development Block Grant (CDBG) money, CETA funds, and Community Mental Health Center (CMHC) funds were treated as "federal", even though they may have come to the community health center through a local mental health center, city government, or other local agency."(7)

1/ Please note that the various financial exhibits use different definitions of fiscal years; differences in accounting procedures also make comparisons difficult.

Federal Funds Include:

Section 330	Basic grants for Community Health Centers in Medically Underserved Areas.
National Health Services Corps	Provides personnel to centers in Health Manpower Shortage Areas.
Community Development Block Grants	Funds used for capital improvements as well as services.
Community Mental Health Center	Provides funds for the provision of mental health services.
Comprehensive Employment and Training Act (CETA)	Provides subsidies for employing or training the unemployed.

Unrestricted

Other

State Funds Include:

Department of Mental Health

Department of Education

Department of Elder Affairs

Department of Social Services

Department of Public Health
- Dental Division
- Women Infant and Children (WIC)
- Maternity and Infant Care (MIC)
- Children and Youth (CY)
- Family Planning
- Alcoholism
- Teen Pregnancy

Other (e.g., unrestricted, primary care, adolescent care, etc.)

Many of these programs are now near extinction (e.g., CETA) or the available funds have been decreased as the programs have become part of the various health care block grants. Thus, in order to maintain the current level of revenue, either additional subsidies have to be found or additional fees have to be generated.

As Exhibit 8 depicts, Section 330 funding decreased 30% from Fiscal 1981 to 1982, for a loss of $1,307,940 in the United Way of Massachusetts Bay service area. Although Congress passed supplemental funds primarily for health prevention and promotion programs, there is no guarantee such supplemental appropriations will be continued. In addition, Section 330 funds for certain health centers in the area are being phased out due to federal redefinitions of Medically Underserved Areas and Health Manpower Shortage Areas[2/] or by the centers' inability to meet other federal requirements for funding. (Exhibit 9 depicts the Bureau of Community Health Services Administrative Indicators for funding.) The future status of the ten health centers affiliated with the Cambridge Hospital is currently in question. Two centers have recently affiliated with hospitals partially as a result of decreasing federal dollars.

The Massachusetts legislature has appropriated $1 million for Community Health Centers for this fiscal year (FY1983). The funds will be distributed based upon proposals solicited through a Request for Proposal (RFP) process. Most of the money is earmarked for centers in Medically Underserved Areas. The RFP contains a strong recommendation that proposals be oriented to patient care and service delivery. The Department of Public Health has included a request for a similar amount of money in its FY1984 budget submission, although it is by no means guaranteed that this appropriation will be repeated.

Many health centers receive funds from their local governments. With the passage of Proposition 2½, however, local funds as a percent of total revenue are decreasing and in Boston's centers dropped on average from 24% in 1979 to 17% in 1981. (See Exhibit 5)

2/ These redefinitions are based on infant mortality statistics, the percent of elderly in the population, the physician/population ratio, and the level of poverty in the area. The redefinitions are being contested.

Certain services provided at health centers, for example social services, preventive health programs, nutrition, and dental care are not covered by many third-party payers. Much of the subsidy funds are used to cover the cost of these services as well as the primary medical care services.

b. Direct Sources

All community health centers have a sliding fee scale for patients who cannot pay the full charge for services. Direct payments accounted, on average, for about 16% of total revenue in 1981, up from 9% in 1977. (See Exhibit 6) Health centers see this revenue source as a major problem area in the future, as unemployment and changing welfare and Medicaid eligibility requirements increase the number of patients without third-party coverage.

Medicaid is decreasing as a percent of total revenue, although it still accounts for a large proportion of primary care revenue. (See Exhibit 10; also Exhibit 6) Medicaid rates are relatively equal across centers. (See Exhibit 11)

A contract with Blue Cross for ambulatory care coverage is under discussion, although some payments by Blue Cross to health centers began last year.

It is important to note that although they are considered third-party insurance, Medicaid and Medicare are funded substantially from public monies, both state and federal.

4. The Future of Community Health Centers

Experts in the field of health center funding were interviewed to determine their best judgments as to future funding, the provision of free care and the perceived future role of health centers in the health care delivery system.

a. Service Provision

All agreed that health centers play a needed role in providing medical care to individuals without private insurance, or the ability to pay the entire cost of care. There is some disagreement, however, as to whether or not all current facilities are "needed". (Please note that a formal needs assessment for any of the services provided by health centers was not requested and is not a part of this report.)

Health centers primarily serve people in the neighborhoods in which the centers are located. If a particular center closed, people might either

i. travel to community health centers in other neighborhoods;

ii. not seek care for a specific condition until it becomes an emergency; or

iii. seek care for minor conditions in a hospital emergency room.

Most individuals interviewed felt actions (ii) or (iii) were the most likely. Indeed such actions have already begun. Such results would, of course, increase the system-wide cost of health care. Any positive impact on health status achieved by the comprehensive, primary care services provided at community health centers would be diminished. In addition, there is always the potential that hospitals, given fixed budgets, would begin to refer non-urgent patients to other sources of care.

b. Funding

Numerous efforts are currently underway to seek funds for health centers. The state's $1,000,000 appropriation is one result. The RFP for these funds requires the results of a need/demand analysis as a means of insuring that the funds are distributed to services most needed by the population. The Massachusetts League of Community Health Centers continues to lobby, as does the national association of health centers, for federal and other funds. Managed health programs, and Commonwealth Health Care Corporation seek, ultimately, to increase efficiency (within a specific site as well as system-wide) and thus receive more per Medicaid dollar spent.

No one interviewed felt they could make a definitive statement, or a specific projection, about any given federal, state, or local program. All stressed that the majority of the revenue generated by health centers is from federal and state sources; it is not generated as the result of specific client-paid fees-for-services as in most health care settings. (See Exhibits 4 through 7)

The amount of subsidized care in health centers varies greatly by site; the range in the percentage of total revenue resulting from subsidy funds is 17 to 74%.

In total, the subsidy programs previously discussed accounted, in FY1981, for over $14,184,500 out of the total revenues of $29,450,000 in the independently-licensed centers in the United Way of Massachusetts Bay service area. Of this subsidy, $8,341,160 was from federal and state sources, $3,988,830 from local governments.

These federal, state and local programs were developed to provide health care services (for example nutrition supplements to women, infants, and children) for those unable to pay. As the availability of federal funds decreases, as Proposition $2\frac{1}{2}$ is implemented, and as welfare and Medicaid eligibility changes, so will the available public dollars. Thus, health centers are looking for alternate sources of funding.

In FY1981, private and donated sources accounted for $1,845,100 out of total revenues of $29,450,000 in independently-licensed centers.

5. United Way-Affiliated Visiting Nurse Associations and Free Care

In 1978, a Subcommittee on Free Care of the United Way Visiting Nurse and Home Care Services Review Committee recommended that a portion of the "uncollectibles" faced by the Visiting Nurse Associations (VNA's) be considered "free care" and thus eligible for United Way funding. "Uncollectibles" include contractual adjustments from Medicaid, the Department of Elder Affairs, debts of full-pay patients, and insurance companies. Total uncollectible billings are expected to be over $600,000 in 1983. (See Exhibit 12) No monies have been allocated to VNA's to cover uncollectibles due to insufficient United Way funds.

6. Impact of United Way Funds on Other Sources of Revenue

Certain private sources of revenue may decrease, or increase, their support of a health center if that center receives United Way funds. In the public sector, Section 330 Public Health Service funds do not automatically decrease if a center receives philanthropic dollars. The Massachusetts Rate Setting Commission, which sets Medicaid rates, treats contributions differently depending on whether the donated monies are restricted or not. If a contribution is unrestricted, or for general operating purposes, the contribution is offset against income. The end result is that a center's Medicaid rate could decrease if it received such funds. If philanthropic dollars are designated by the donor for a specific program, however, the funds are not offset.

Thus, in order to not adversely impact a center's Medicaid rate, and in order to cause a net increase in a center's total revenue, United Way contributions would need to be restricted to a particular program.

7. Funding of Health Care and Community Health Centers in Other Large United Ways

A United Community Planning Corporation survey of United Way organizations serving large metropolitan areas revealed that twelve of the thirty-three responding Metro I's[3/] fund community health centers. Major reasons for such funding include:

a. Extremely needy populations (defined either geographically or by population characteristic) are served;

b. Excellent medical care is provided; and

c. Volunteers provide a major proportion of the medical care.

Twenty-one (64%) United Way Metro I's do not fund community health centers. Three major reasons for non-funding emerged:

a. There is no tradition of funding for health care;

b. Funding for such health care services is a public rather than a private responsibility; and

c. Funding for health centers would require too much money.

Exhibit 13 provides a more detailed discussion of other Metro I United Way organizations and the funding of community health centers. It is interesting to note (See Table 3 within Exhibit 13) that, after the initial affiliation, other health centers were not admitted as affiliates to any great extent. As Table 4 depicts, the amount allocated ranges from $28,000 to $361,919.

3/ Metro I's are defined as those United Way organizations which raise $9,000,000 or more in the annual campaign.

A study conducted by John Tierney for United Way of America revealed that United Way dollars declined as a percent of health agencies' total income from 1963 to 1976. As proportionate public support for health care increased, United Way support has decreased. Tierney argues that

> "voluntary support, through planning, program development and funding health services, must not diminish. In absolute terms, voluntary support of health cannot keep pace with public support. Yet, the involvement and influence of the voluntary sector can and should be strengthened, having greater impact on the evolving health service system." (8)

Tierney also argues that concentrating on prevention-oriented services is a means of achieving this impact.

D. OPTIONS FOR UNITED WAY FUNDING OF COMMUNITY HEALTH CENTERS

Six potential United Way of Massachusetts Bay alternative financing arrangements for community health centers are described briefly and followed by a list of the positives and negatives of each alternative from the United Way perspective.

The narrative sections following the options provide information about some of the factors involved.

The options discussed are:

1. To provide support to community health centers by funding Free Care;
2. To provide support for Mental Health Counseling;
3. To provide support for Primary Health Care Services;
4. To provide support for Preventive Health Services;
5. To provide no financial support to Community Health Centers; and
6. To provide support to the Massachusetts League of Community Health Centers, an association of health centers across the state.

Section E presents additional information on the financial implications of each alternative.

Option 1: To provide support to Community Health Centers by funding Free Care.

Accepting this financial arrangement would mean paying for care received at community health centers by individuals not covered by insurance or unable to pay for it themselves. "Free Care" could be restricted by service provided. For example, only prenatal or pediatric care, to cite two primary care possibilities, could be supported. The service covered could vary by health center and thus the needs of the specific population served. Another possibility would be to select one specific service (e.g., pediatrics) for free-care funding and accept as affiliates only those health centers which serve a population in need of this type of subsidy.

The financial commitment for this type of funding arrangement is potentially enormous, given changes in federal funding for health centers, block grants for many other health care programs, the loss of insurance coverage due to unemployment, and changing Medicaid eligibility requirements. However, United Way support could be controlled by placing limits on the dollar amount provided to each center; by narrowly defining the types of service to be supported; or by narrowly defining those eligible for such support. (For example, teenagers applying for prenatal care could be the only eligible patients.)

PROS	CONS
a) Concentrate United Way financial support on underserved populations.	a) Funds required to make a major impact may cause inordinate demands on the campaign unless specific limits are placed.
b) Other sources of subsidy funds are decreasing.	b) Free care provided by Visiting Nurse Associations is not totally funded. (See Exhibit 12)
c) Funds could be restricted to programs most needed in the specific community as well as to individuals most in need.	c) Medical care for those unable to pay is a responsibility of the public, not the private, sector.
d) Depending on Rate Setting, United Way might develop a system for funding any service for an individual truly in need.	

Option 2: To provide support for Mental Health Counseling.

Counseling is one of the services currently supported by United Way. It is also offered in most community health centers. Mental health services, in 1979, comprised 12% of total visits in the Boston community health centers. Such services are often not covered by third-party payers after the initial $500 mandated coverage expires, or not covered at all.

The financial commitment involved in this type of funding arrangement could be limited by selecting agencies which provide services only in those areas which United Way affiliates currently do not serve. In 1981, United Way spent $2.1 million on counseling services.

PROS	CONS
a) AEP ranked "B".	a) Counseling services receive more funds than any other United Way service.
b) Many third-party payers do not fund all such services.	b) The Health and Rehabilitation Review Committee and the Social Services Review Committee are planning to review the United Way role in funding mental health services and counseling in light of the large sums of money being spent in this service. Acceptance of new agencies providing this service should await the Review Committees' evaluation.
c) Individuals may postpone seeking this service longer than seeking a medical service if they have no money to pay for it.	

Option 3: To provide support for Primary Health Care services.

Primary health care is generally considered to include internal medicine, pediatrics, obstetrics and gynecology. Private third-party insurers, Medicare and Medicaid pay for such services if individuals have coverage. In certain instances the reimbursement received may be less than the full cost of providing the care.

United Way's financial commitment, if this option is selected, could be limited by combining this option with the free care option; by selecting health centers for funding only if no other source of ambulatory health care is located within the geographic area served; or by funding centers which serve a population group not adequately served elsewhere (e.g., linguistic minorities).

PROS	CONS
a) Most health centers serve areas defined as medically underserved.	a) All community health center clients might ultimately be included in this service category; too open ended both in terms of financial commitment and people served.
b) Other sources of subsidies for primary health care are decreasing.	b) Support of the direct provision of health care on a large scale would be a major change for United Way.
c) Utilization at low cost primary care settings needs to be encouraged.	c) United Way funding may discourage attempts to improve third-party payments for such services.
d) Insurance coverage is decreasing as unemployment rises and Medicaid eligibility requirements tighten.	d) United Way dollars might be seen as subsidizing governmental programs.
	e) Primary health care is too extensive a service package.

Option 4: To provide support for Preventive Health Services

Preventive health services are currently supported by United Way. Included in this service are categorical health education and promotion programs sponsored by health agencies, alcoholism programs, nutrition, swimming safety, Cardio-pulmonary Resuscitation (CPR) training, home health promotion visits, and screening programs. Community health centers emphasize preventive health services and offer programs such as smoking clinics, hypertension screening, prenatal care, weight control, nutrition and alcohol counseling, and outreach programs.

United Way's financial commitment, if this option is adopted, could be limited by providing funding only for agencies serving a population not currently served by other United Way affiliates' prevention programs. In 1981 $1.2 million was spent on preventive health by United Way; only counseling, day care, and social group development received more United Way dollars.

PROS	CONS
a) AEP ranked "B".	a) Visiting Nurse Associations provide health promotion visits to the elderly.
b) Most third-party payers do not fund preventive health services.	b) The federal initiative in terms of supplemental funding for prevention services may be repeated.
c) Other subsidy dollars are decreasing.	c) United Way agencies currently provide many preventive health services.
d) Prevention services provided by community health centers would enhance the preventive health package supported by United Way.	

Option 5: To provide no financial support to Community Health Centers.

Another option is to take no action toward funding health centers. Accepting this arrangement would incur no financial expense for the United Way. Campaign funds which might have been allocated to Community Health Centers could be spent on services provided by current affiliates, or other new affiliated agencies.

PROS

a) Medical care is a public, not private, responsibility.

b) The state legislature has recently appropriated $1 million for health centers. Increasing private support may discourage such public initiatives in the future.

c) United Way does not have sufficient funds available to make a major impact in this area.

d) Additional free care at VNA's could be funded.

CONS

a) A needed community service may disappear.

b) A small amount of money may be all that is needed in some centers to continue to provide services.

c) Community health centers are cost efficient providers of health care. Encouraging their continued existence would have far-reaching implications for the health care system.

d) Community health centers are community oriented and usually community controlled. These factors are looked upon favorably by United Way.

e) Given public funding cuts, United Way may be critically important for some centers.

Option 6: To provide support to the Massachusetts League of Community Health Centers, an association of health centers across the state.

The Massachusetts League of Community Health Centers is an association of community health centers. It's goals are to "(i) strengthen community health centers by providing technical assistance in the areas of management, medical practices, and fiscal planning; (ii) to advocate on behalf of community health centers and the consumers they serve before local, State and Federal health-related agencies; and (iii) to garner new resources for all community health centers by acting as facilitator and agent." (6)

Accepting this financial arrangement would mean providing funds to a trade association to act in behalf of its entire, statewide membership to seek funds from other sources or to assist in improving operational efficiencies at centers.

The financial commitment for this type of funding arrangement could be limited to a given number of staff positions.

PROS	CONS
a) Potential to assist many centers and users at once.	a) United Way's current policy is not to fund trade associations. It is felt that member organizations should provide sufficient support.
b) Limited United Way financial commitment.	b) The League is an advocacy organization for agencies before governmental bodies.
c) United Way's Development Fund might be appropriate for this, given changes in federal funding.	c) United Way dollars are more appropriately used for direct services.
	d) United Way dollars are more appropriately given to their ultimate user.

Option 6 (Continued)

PROS	CONS
–	e) Such a relationship is more appropriate in the short term rather than the traditional, United Way long-term association with agencies.
	f) Affiliation with one trade association may set a precedent.

E. FINANCIAL IMPLICATIONS FOR UNITED WAY

In the absence of the results of a needs assessment for each service provided by community health centers, it is difficult, if not impossible, to estimate the total cost of continuing the provision of necessary services. However, in order to provide some perspective on United Way's potential contribution, one can look at estimates of average costs per encounter or per program. Health centers vary greatly in their cost structures; the following estimates are based on averages.

Dollar estimates provided in the following discussion are for one year only. Community health centers are ongoing, accepted sources of care. Unlike the one-time start-up support for a new service, hospices, community health centers would most probably be requesting a long-term association with United Way. Given the past rate of increase in the cost of health care, requested support can be expected to rise each year. In addition, it should be reiterated that in other United Way areas community health centers did not affiliate to any great extent after the initial center was accepted. Boston is somewhat unusual, however, in the number of health centers it has.

In FY 1981, primary care, on average, cost $35 per encounter in the independently-licensed centers. The range was from $21 to $53. (Rate Setting Commission data. It may be recalled that the average Medicaid rate is now $30.80.) Assuming that the 1-2% rate of increase in the past was not maintained and that costs rose 5% per year, the average cost per encounter in Fiscal 1983 would be $38.60. For the following dollar contributions United Way could thus expect to support in full the following number of patient encounters:

Allocation	Encounters
$ 50,000	1,295
100,000	2,590
150,000	3,890
200,000	5,180
250,000	6,475

Mental health costs vary greatly across health centers due to different types of services offered and staffing patterns. In Fiscal 1979 mental health costs averaged $43 per encounter.(2) Assuming a 7% increase each year (the same increase as occurred in such costs from 1978 to 1979), the average cost per encounter in Fiscal 1983 is $56. The following describes United Way's return on its dollars if they are allocated to mental health at health centers:

Allocation	Encounters
$ 50,000	890
100,000	1,785
150,000	2,680
200,000	3,570
250,000	4,465

Prevention programs are often self-contained and project oriented; United Way dollars could be controlled by funding specific programs at specific sites. Funding and support services for one staff person could cost between $20,000 and $40,000. If all independently-licensed centers which did not receive a Section 330 supplemental award (fourteen sites) received $25,000 the cost to United Way would be $350,000.

Subsidized care at community health centers, as discussed, amounts to over $14,000,000 in Boston and includes all services. As public revenue sources decrease, and to the extent that patient payments do not increase substantially, community health centers may experience bad debts. The extent of such debts may be greatest in the centers with the lowest private insurance and Medicaid-supported population. Given the difficulty of providing unrestricted monies to health centers, as well as the potential for requests to replace any and all subsidy decreases, United Way might best control expenditures in this area by simply placing a dollar limit on support.

Funding the association of health centers, unlike the previous alternatives, could be a short-term arrangement. One or two staff positions, jointly funded by the League's membership, could be supported. The cost to United Way could be as low as $20,000 per year.

It is important to reiterate that the previous financial discussion is based on estimates. The needs assessment, by program, in each community from which a health center applies for funding will best reveal what services are required and thus what resources are needed to assist in providing them.

F. RELATIVE MERIT OF THE OPTIONS

The following ranking of alternatives was developed in the absence of a formal needs assessment. The discussion is based on perceptions of community need, future funding from other sources, and our understanding of United Way concerns.

Support of preventive health services (Option 4) seems to be the most appropriate, as well as the most feasible, funding arrangement. Prevention programs do not generally receive third-party reimbursement, yet they have a long-lasting impact on the health of the population. Tierney stresses prevention as an area for appropriate present/future United Way support. (8) United Way could fund programs tailored to the needs of the particular community served by each community health center which applied. Acceptance of this option would expand United Way's role in prevention to a broader population as well as provide more medically-oriented prevention services (e.g., prenatal care). The cost of adoption of this alternative is relatively easily controlled.

Free care for primary care services (Option 1 merged with Option3) would seem to come next in order of priority. (Primary care without this restriction - Option 3 - would be too difficult to control in terms of cost to United Way.) As individuals lose insurance coverage, be it private or public, they may be reluctant to seek care. United Way could explore the possibility of providing funds to health centers to subsidize their sliding fee scale for medical services. As a result, centers would not have to drastically raise patient fees, yet patients would continue to contribute to the cost of their care.

Given that United Way Review Committees are in the process of reviewing United Way's role in mental health, it would be advisable to await the results of that review before accepting new affiliates which provide counseling services. (Option2)

Funding the Massachusetts League of Community Health Centers (Option 6) would set a precedent for affiliating with trade associations. There does not appear to be any compelling reason in this case to over-ride United Way's previous negative recommendations on similar cases.

To do nothing (Option 5) would be inappropriate. Given the public funding cuts in health services and the potential for additional decreases in the future, United Way support would assist in the maintenance of low cost, quality health services in neighborhoods where other sources of care are scarce.

G. EXHIBITS

EXHIBIT I

COMMUNITY HEALTH CENTERS IN THE UNITED WAY OF MASSACHUSETTS BAY SERVICE AREA

BOSTON

Independently Licensed

BOSTON EVENING MEDICAL CENTER
314 Commonwealth Avenue
Boston, MA 02115

CODMAN SQUARE HEALTH CENTER
6 Norfolk Street
Dorchester, MA 02124

COLUMBIA POINT HEALTH CENTER
300 Mt. Vernon Street
Dorchester, MA 02125

DIMOCK COMMUNITY HEALTH CENTER
55 Dimock Street
Rosbury, MA 02119

DORCHESTER HOUSE MULTI-SERVICE CENTER
1353 Dorchester Avenue
Dorchester, MA 02122

EAST BOSTON NEIGHBORHOOD HEALTH CENTER, INC.
10 Grove Street
East Boston, MA 02128

FENWAY COMMUNITY HEALTH CENTER, INC.
16 Haviland Street
Boston, MA 02115

HARVARD STREET NEIGHBORHOOD HEALTH CENTER
895 Blue Hill Avenue
Dorchester, MA 02124

JOSEPH M. SMITH COMMUNITY HEALTH CENTER
51 Stadium Way
Allston, MA 02134

MATTAPAN COMMUNITY HEALTH CENTER, INC.
1425 Blue Hill Avenue
Mattapan, MA 02126

Hospital-Licensed

BOWDOIN STREET HEALTH CENTER
200 Bowdoin Street
Dorchester, MA 02122 (Carney)

BROOKSIDE PARK FAMILY LIFE CENTER
3297 Washington Street
Jamaica Plain, MA 02130
(Brigham and Women's)

BUNKER HILL HEALTH CENTER
73 High Street
Charlestown, MA 02129
(Massachusetts General)

GREATER ROSLINDALE HEALTH CENTER
6 Cummins Highway
Roslindale, MA 02131 (Carney)

LABOURE CENTER*
371 W. Fourth Street
South Boston, MA 02127
(St. Margaret's)

LITTLE HOUSE HEALTH CENTER*
900 Dorchester Avenue
Dorchester, MA 02125
(Carney)

MARTHA MAY ELIOT HEALTH CENTER
33 Bickford Street
Jamaica Plain, MA 02130
(Children's)

SOUTHERN JAMAICA PLAIN HEALTH CENTER
687 Centre Street
Jamaica Plain, MA 02130
(Brigham and Women's)

EXHIBIT I (Continued)

COMMUNITY HEALTH CENTERS IN THE UNITED WAY OF MASSACHUSETTS BAY SERVICE AREA

BOSTON

Independently Licensed

NEPONSET HEALTH CENTER
398 Neponset Avenue
Dorchester, MA 02122

NORTH END COMMUNITY HEALTH CENTER
332 Hanover Street
Boston, MA 02113

ROXBURY COMPREHENSIVE COMMUNITY HEALTH CENTER
435 Warren Street
Roxbury, MA 02115

ROXBURY DENTAL AND MEDICAL GROUP
185 Dudley Street
Roxbury, MA 02119

SOUTH BOSTON COMMUNITY HEALTH CENTER
133 Dorchester Avenue
South Boston, MA 02127

SOUTH COVE COMMUNITY HEALTH CENTER
885 Washington Street
Boston, MA 02111

SOUTH END COMMUNITY HEALTH CENTER
400 Shawmut Avenue
Boston, MA 02118

UPHAM'S CORNER HEALTH CENTER
500 Columbia Road
Dorchester, MA 02125

WHITTIER STREET NEIGHBORHOOD HEALTH CENTER
20 Whittier Street
Roxbury, MA 02020

Hospital-Licensed

NOTE: Bridge Over Troubled Waters, a United Way affiliate, is considered by some to be a community health center due to its membership in the Massachusetts League of Community Health Centers. It is not included in this list, nor in most other lists of community health centers because it does not provide continuing care to a population in a defined geographic area. Bridge's medical van is a mobile unit.

* These health centers are associated with United Way-affiliated agencies but are financially independent from the affiliates.

EXHIBIT I (Continued)

COMMUNITY HEALTH CENTERS IN THE UNITED WAY OF MASSACHUSETTS BAY SERVICE AREA

OUTSIDE BOSTON

Independently Licensed

HULL MEDICAL CENTER
180 George Washington Boulevard
Hull, MA 02045

LYNN COMMUNITY HEALTH CENTER
86 Lafayette Park
Lynn, MA 01902

MANET COMMUNITY HEALTH CENTER, INC.
1193 Sea Street
Quincy, MA 02169

NORTH SHORE COMMUNITY HEALTH CENTER
39 Walnut Street
Peabody, MA 01960

60+ CLINIC
One Davis Square
Somerville, MA 02144

Hospital-Licensed

THE CAMBRIDGE HOSPITAL NEIGHBORHOOD HEALTH CENTERS
1493 Cambridge Street
Cambridge, MA 02139 (10 sites)

CHELSEA MEMORIAL HEALTH CARE CENTER OF MASSACHUSETTS GENERAL
100 Bellingham Street
Chelsea, MA 02150

EAST SOMERVILLE HEALTH CENTER
61 Glen Street
Somerville, MA 02145
(Somerville)

FOXBORO AREA HEALTH CENTER
30 Mechanic Street
Foxboro, MA 02035 (Norwood)

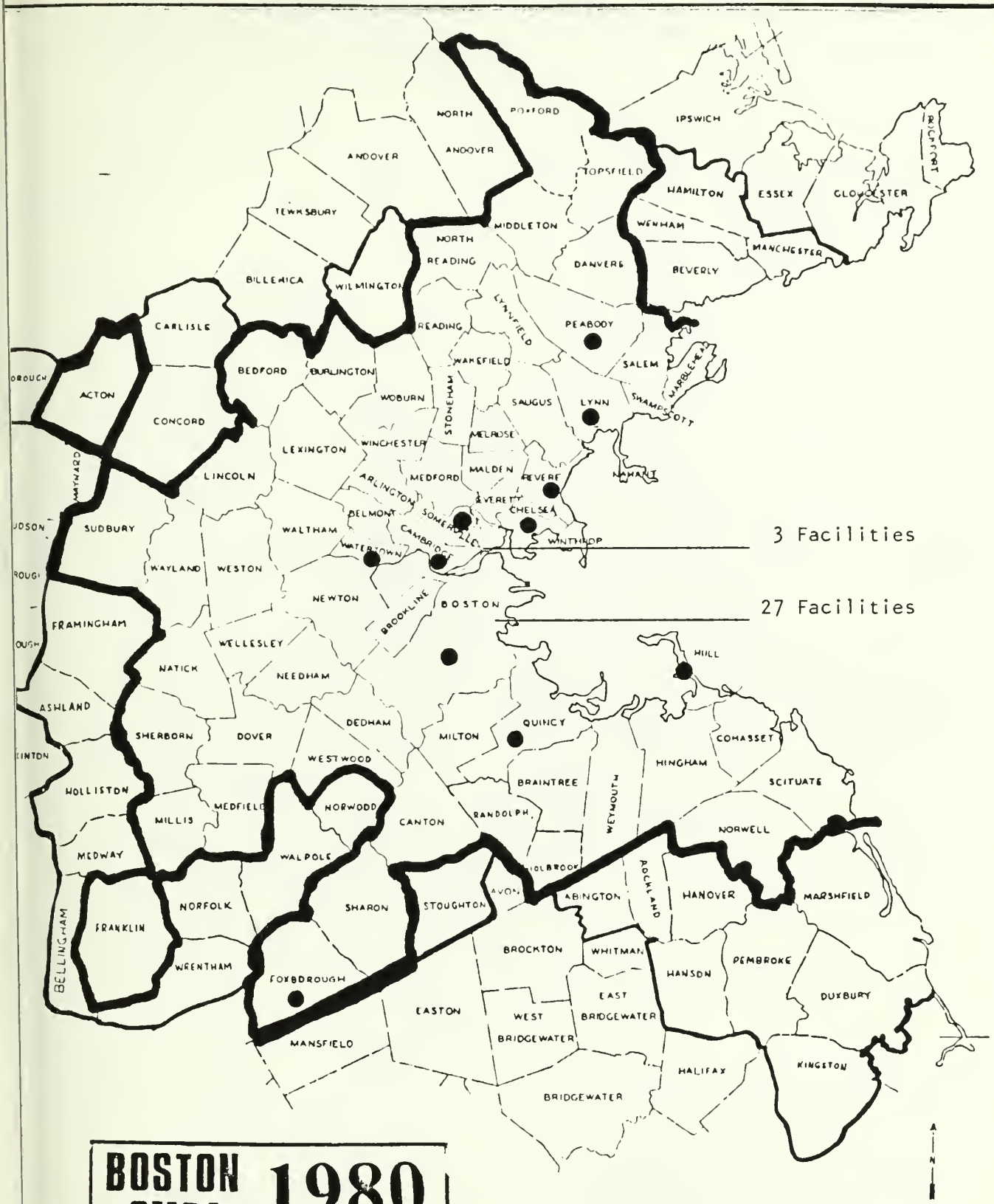
MYSTIC HEALTH CENTER
Aero River Road
Somerville, MA 02145 (Somerville)

REVERE HEALTH CENTER
199 Revere Street
Revere, MA 02151
(Massachusetts General)

WATERTOWN HEALTH CENTER
85 Main Street
Watertown, MA 02172
(St. Elizabeth's)

EXHIBIT I (continued)

CATION OF COMMUNITY HEALTH CENTERS IN THE UNITED WAY OF MASSACHUSETTS BAY SERVICE AREA



BOSTON SMSA 1980

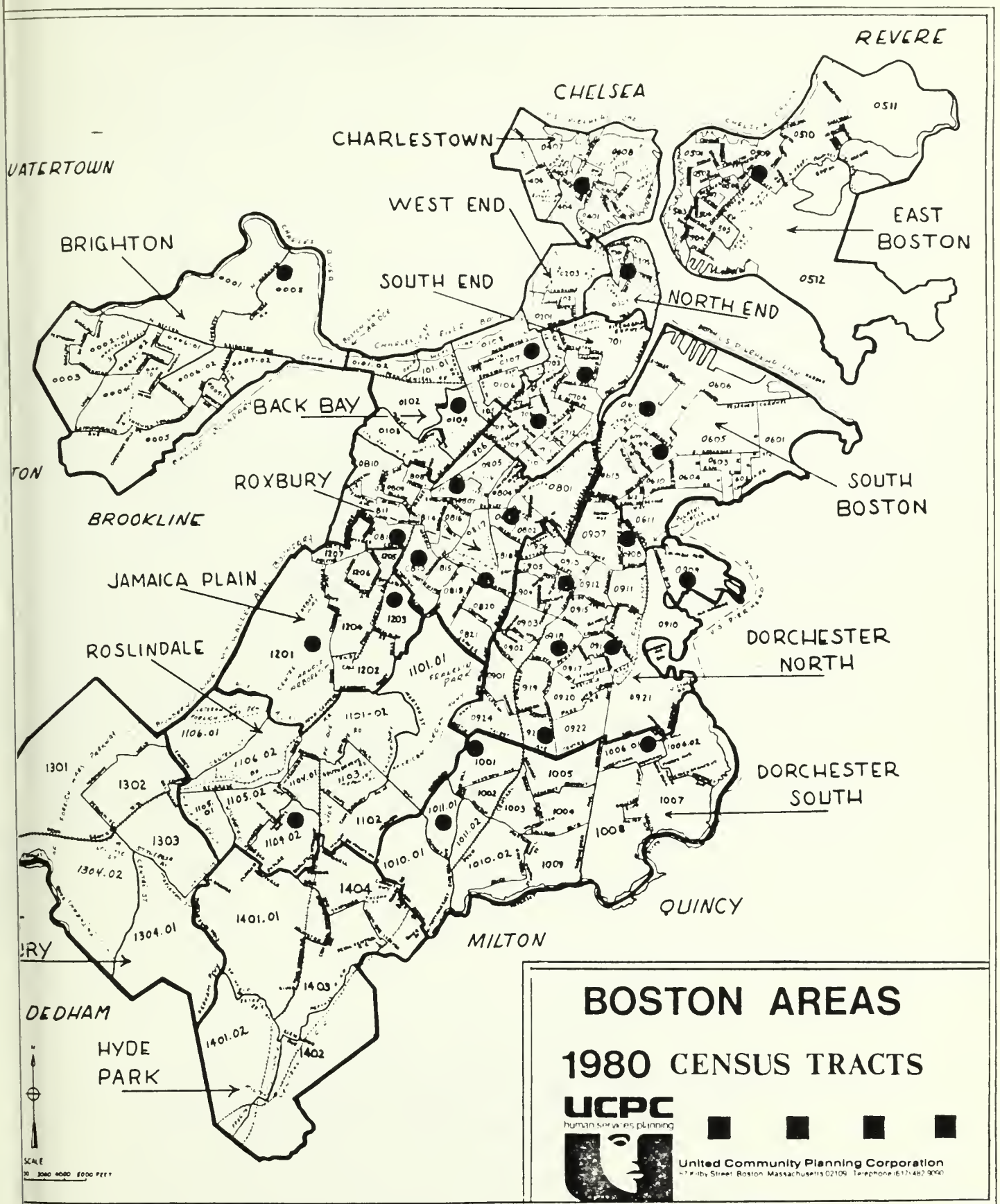
UCPC

United Community Planning Corporation

87 Kilby Street, Boston, Massachusetts 02109 Telephone (617) 482-9090

EXHIBIT 1 (continued)

LOCATION OF COMMUNITY HEALTH CENTERS IN BOSTON



TOTAL PRIMARY CARE VISITS, AND MEDICAID VISITS, FOR
COMMUNITY HEALTH CENTERS IN METROPOLITAN BOSTON.
CALENDAR 1981 CLOSING ESTIMATES

BOSTON	Total Primary Care Visits	Medicaid Visits	% Medicaid Visits
Boston Evening	20,000	2,000	10.0%
Bowdoin Street	11,500	5,200	45.2
Brookside Park	52,000	27,000	51.9
Bunker Hill	55,000	16,500	30.0
Codman Square	6,000	2,800	46.7
Columbia Point	20,000	11,500	57.5
Dimock	20,000	10,400	52.0
Dorchester House	40,000	15,000	37.5
East Boston	120,000	27,000	22.5
Fenway	15,000	600	4.0
Greater Roslindale	15,000	3,000	20.0
Harvard Street	48,000	26,000	54.2
Joseph M. Smith	19,000	4,000	21.1
Laboure	12,000	3,000	25.0
Little House	22,000	6,500	29.5
Martha May Eliot	33,000	23,000	69.7

EXHIBIT 2

TOTAL PRIMARY CARE VISITS, AND MEDICAID VISITS, FOR COMMUNITY HEALTH CENTERS IN METROPOLITAN BOSTON. CALENDAR 1981 CLOSING ESTIMATES (Cont...)

BOSTON (Cont...)	Total Primary Care Visits	Medicaid Visits	% Medicaid Visits
Mattapan	15,000	7,000	46.7%
Neponset	37,000	7,800	21.1
North End	57,000	12,000	21.1
Roxbury Comprehensive	48,000	26,400	55.0
Roxbury Dental and Medical Group	16,500	11,500	69.7
South Boston	24,500	7,800	31.8
South Cove	44,000	14,500	33.0
South End	50,000	35,000	70.0
Southern Jamaica Plain	18,000	4,400	24.4
Upham's Corner	42,000	18,000	42.9
Whittier Street	21,500	11,800	54.9
TOTAL BOSTON	882,000	339,700	38.5%
GREATER BOSTON			
Cambridge Hospital	75,000	30,000	40.0%
Chelsea	65,630	21,876	33.3
East Somerville	n/a	n/a	n/a

EXHIBIT 2 (continued)

TOTAL PRIMARY CARE VISITS, AND MEDICAID VISITS, FOR COMMUNITY HEALTH CENTERS IN METROPOLITAN BOSTON. CALENDAR 1981 CLOSING ESTIMATES (Cont...)

GREATER BOSTON (Cont...)	Total Primary Care Visits	Medicaid Visits	% Medicaid Visits
Foxboro	n/a	n/a	--
Hull	10,000	3,000	30.0%
Lynn	21,000	7,000	33.3
Manet	12,000	1,800	15.0
Mystic	n/a	n/a	n/a
North Shore	10,000	4,720	47.2
Revere	12,000	4,000	33.3
60+ Clinic	4,000	--	--
Watertown	14,000	4,666	33.3
TOTAL GREATER BOSTON	223,630	77,062	34.5%
TOTAL, UWMB SERVICE AREA	1,105,630	416,762	37.7%

SOURCE: Massachusetts League of Community Health Centers

EXHIBIT 2 (continued)

TOTAL REVENUE FOR INDEPENDENTLY LICENSED COMMUNITY HEALTH CENTERS
IN THE UNITED WAY OF MASSACHUSETTS BAY SERVICE AREA

BOSTON	REVENUE
BOSTON EVENING	$ 635,009
CHARLES DREW	691,094
CODMAN SQUARE	192,382
COLUMBIA POINT	740,353
DIMOCK	1,390,980
DORCHESTER HOUSE	1,391,324
EAST BOSTON	4,553,662
GREATER ROSLINDALE	406,734
HARVARD STREET	2,681,390
JOSEPH M. SMITH	566,221
MATTAPAN	468,418
NEPONSET	1,178,459
NORTH END	1,578,948
ROXBURY COMPREHENSIVE	2,573,510
ROXBURY DENTAL AND MEDICAL	730,852
SOUTH BOSTON	1,058,967
SOUTH COVE	1,789,974
SOUTH END	1,290,243
UPHAM'S CORNER	1,311,377
TOTAL BOSTON	$25,229,897

OUTSIDE BOSTON	REVENUE
LYNN	$ 1,000,671
MANET	471,764
NORTH SHORE	174,121
REVERE	2,573,510
TOTAL OUTSIDE BOSTON	$ 4,220,066
TOTAL UNITED WAY OF MASSACHUSETTS BAY SERVICE AREA	$29,449,963

EXHIBIT 3

SOURCE: Internal Office of State Health Planning documents, which utilized Massachusetts Rate Setting Commission Community Health Center Cost Reports, Schedule B.

PERCENTAGE OF TOTAL REVENUE OBTAINED FROM SUBSIDIES OR DIRECT PAY AND THIRD PARTY PAYMENTS FOR BOSTON'S INDEPENDENTLY-LICENSED COMMUNITY HEALTH CENTERS FOR FY 1977, FY 1979, AND FY 1981

BOSTON	Total Subsidy[1]			Total Direct Pay and Third Party Payments[2]		
	1977	1979	1981	1977	1979	1981
Boston Evening	n/a	n/a	17	n/a	n/a	84
Charles Drew	66	64	71	34	36	29
Codman Square	n/a	n/a	71	n/a	n/a	30
Columbia Point	n/a	58	74	n/a	42	26
Dimock	68	71	70	32	29	29
Dorchester House	57	49	49	43	51	51
East Boston	73	49	18	27	51	83
Greater Roslindale	n/a	64	52	n/a	36	48
Harvard Street	72	62	53	28	38	47
Joseph M. Smith	56	69	61	44	30	40
Mattapan	67	58	61	33	42	38
Neponset	63	54	46	37	46	54
North End	85	75	71	15	25	29
Roxbury Comprehensive	81	76	69	19	24	31
Roxbury Dental and Medical Group	50	44	46	50	56	54
South Boston	66	66	56	34	34	44
South Cove	85	73	62	15	27	37

EXHIBIT 4

PERCENTAGE OF TOTAL REVENUE OBTAINED FROM SUBSIDIES OR DIRECT PAY AND THIRD PARTY PAYMENTS FOR BOSTON'S INDEPENDENTLY-LICENSED COMMUNITY HEALTH CENTERS FOR FY 1977, FY 1979, AND FY 1981 (Cont...)

	Total Subsidy[1]			Total Direct Pay and Third Party Payments[2]		
BOSTON (Cont...)	1977	1979	1981	1977	1979	1981
South End	16	14	19	84	86	81
Upham's Corner	64	44	41	36	56	58
Whittier Street	72	56	n/a	28	44	n/a
AVERAGE	65	58	53	35	42	47

EXHIBIT 4 (continued)

NOTES: [1]Subsidy includes Federal, State, Local or City, Private, Donated, and other non-operating revenues.

[2]Direct Pay and Third Party Payments include patients' payments, Medicare, Medicaid, Private Insurance, and other operating revenues.

SOURCE: Compiled from unpublished reports - 1977 and 1979 data from "Community Health Centers In Boston," Health Planning Council of Greater Boston, January 12, 1981; 1981 data from internal Office of State Health Planning documents. Both papers utilized Massachusetts Rate Setting Commission Community Health Center Cost Report, Schedule B, for appropriate years.

COMPONENTS OF TOTAL SUBSIDY AS A PERCENT OF
TOTAL REVENUE FOR BOSTON'S INDEPENDENTLY-LICENSED
COMMUNITY HEALTH CENTERS FOR FY 1977, FY 1979, AND FY 1981

	Federal			State			Local/City			Private and Donated			Other			Total Subsidy[1]		
BOSTON Year 19 :	77	79	81	77	79	81	77	79	81	77	79	81	77	79	81	77	79	81
Boston Evening	n/a	n/a	3	n/a	n/a	0	n/a	n/a	0	n/a	n/a	13	n/a	n/a	1	n/a	n/a	17
Charles Drew[2]	12	10	17	2	4	3	40	50	51	12	0	0	0	0	0	66	64	71
Codman Square[3]	n/a	n/a	6	n/a	n/a	0	n/a	n/a	21	n/a	n/a	41	n/a	n/a	3	n/a	n/a	71
Columbia Point	n/a	41	37	n/a	17	11	n/a	0	0	n/a	0	25	n/a	0	1	n/a	58	74
Dimock	0	27	25	30	10	10	0	4	3	17	18	13	21	12	19	68	71	70
Dorchester House	6	5	8	4	3	6	38	29	23	9	11	10	0	1	2	57	49	49
East Boston	4	4	1	19	13	5	36	26	10	14	5	1	0	1	1	73	49	18
Greater Roslindale	n/a	12	6	n/a	11	0	n/a	14	28	n/a	27	17	n/a	0	1	n/a	64	52
Harvard Street	0	0	0	23	25	15	36	32	37	13	5	1	0	0	0	72	62	53
Joseph M. Smith	0	0	14	0	0	0	37	53	26	18	15	9	1	1	12	56	69	61
Mattapan	36	21	29	0	0	0	15	19	21	16	17	11	0	1	0	67	58	61
Neponset	45	44	35	0	0	0	8	6	5	7	2	2	3	2	4	63	54	46
North End	20	37	37	3	4	4	45	19	13	15	14	15	2	1	2	85	75	71
Roxbury Comprehensive	68	71	65	13	4	4	0	1	0	0	0	0	0	0	0	81	76	69
Roxbury Dental and Medical Group	0	0	0	0	0	3	0	39	4	47	5	39	3	0	0	50	44	46
South Boston	7	7	4	0	0	10	37	54	43	22	5	3	0	0	4	66	66	56
South Cove	38	35	29	0	3	11	20	5	4	26	30	18	1	0	0	85	73	62

EXHIBIT 5

COMPONENTS OF TOTAL SUBSIDY AS A PERCENT OF TOTAL REVENUE FOR BOSTON'S INDEPENDENTLY-LICENSED COMMUNITY HEALTH CENTERS FOR FY 1977, FY 79, AND FY 81, (Cont...)

BOSTON (Cont..)	Year 19 :	Federal			State			Local/City			Private and Donated			Other			Total Subsidy[1]		
		77	79	81	77	79	81	77	79	81	77	79	81	77	79	81	77	79	81
South End		0	0	3	0	0	0	9	14	13	7	0	2	0	0	1	16	14	19
Upham's Corner		1	5	5	24	6	7	39	30	26	0	0	0	0	3	3	64	44	41
Whittier Street		7	3	n/a	24	18	n/a	21	11	n/a	20	18	n/a	0	5	n/a	72	56	n/a
	AVERAGE	15	18	17	9	7	4	24	23	17	15	10	12	2	2	3	65	58	53

EXHIBIT 5 (continued)

NOTES: [1]Totals may vary due to rounding

[2]Closed and absorbed by Harvard Street

[3]Opened in 1979

SOURCES: Compiled from unpublished reports - 1977 and 1979 data from "Community Health Centers In Boston," Health Planning Council of Greater Boston, January 12, 1981; 1981 data from internal Office of State Health Planning documents. Both papers utilized Massachusetts Rate Setting Commission Community Health Center Cost Reports, Schedule B, for appropriate years.

COMPONENTS OF TOTAL DIRECT PAY AND THIRD PARTY PAYMENTS
AS A PERCENT OF TOTAL REVENUE FOR BOSTON'S INDEPENDENTLY-LICENSED COMMUNITY HEALTH CENTERS
FOR FY 1977, FY 1979, AND FY 1981

	Direct			Medicaid			Medicare			Private Insurance and Other			Total Direct Pay and Third Party Payer[1]		
BOSTON Year 19 :	77	79	81	77	79	81	77	79	81	77	79	81	77	79	81
Boston Evening	n/a	n/a	49	n/a	n/a	5	n/a	n/a	2	n/a	n/a	28	n/a	n/a	84
Charles Drew[2]	4	4	n/a	27	31	n/a	0	0	n/a	4	0	n/a	34	36	29
Codman Square[3]	n/a	n/a	8	n/a	n/a	21	n/a	n/a	*	n/a	n/a	*	n/a	n/a	30
Columbia Point	n/a	2	2	n/a	31	20	n/a	0	2	n/a	9	2	n/a	42	26
Dimock	13	11	15	17	15	13	0	0	*	2	2	*	32	29	29
Dorchester House	12	18	19	25	25	21	1	2	4	4	5	7	43	51	51
East Boston	2	3	3	14	17	17	5	10	22	6	21	41	27	51	83
Greater Roslindale	n/a	17	21	n/a	19	18	n/a	0	6	n/a	0	3	n/a	36	48
Harvard Street	3	8	10	24	23	28	0	0	*	1	7	8	28	38	47
Joseph M. Smith	31	23	32	8	4	n/a	2	3	3	3	0	5	44	30	40
Mattapan	5	7	11	28	35	26	0	0	0	0	0	1	33	42	38
Neponset	17	20	23	12	12	14	6	9	10	2	5	7	37	46	54
North End	n/a	n/a	13	n/a	n/a	8	n/a	n/a	5	n/a	n/a	3	15	25	29
Roxbury Comprehensive	3	4	4	15	19	24	0	1	1	1	0	2	19	24	31
Roxbury Dental and Medical Group	14	18	n/a	32	34	34	4	4	3	0	0	n/a	50	56	54
South Boston	6	6	10	20	23	19	3	2	6	5	3	9	34	34	44
South Cove	n/a	13	23	n/a	11	11	n/a	1	1	n/a	2	2	15	27	37

EXHIBIT 6

COMPONENTS OF TOTAL DIRECT PAY AND THIRD PARTY PAYMENTS AS A PERCENT OF TOTAL REVENUE FOR BOSTON'S INDEPENDENTLY-LICENSED COMMUNITY HEALTH CENTERS FOR FY 1979, FY 1979, AND FY 1981 (Cont...)

BOSTON (Cont...)	Direct			Medicaid			Medicare			Private Insurance and Other			Total Direct Pay and Third Party Payer[1]		
Year 19 :	77	79	81	77	79	81	77	79	81	77	79	81	77	79	81
South End	6	5	n/a	76	78	n/a	1	1	n/a	1	2	n/a	84	86	81
Upham's Corner	3	5	8	24	40	40	8	10	9	1	1	1	36	56	56
Whittier Street	4	n/a	n/a	23	n/a	n/a	0	n/a	n/a	1	n/a	n/a	28	44	n/a
AVERAGE	9	10	16	25	26	20	2	3	4	2	4	8	35	42	47

EXHIBIT 6 (continued)

NOTE: *Less than 1%

[1]Totals may vary due to rounding

[2]Closed and absorbed by Harvard Street

[3]Opened in 1979

SOURCE: Compiled from unpublished reports-1977 and 1979 data from "Community Health Centers in Boston," Health Planning Council of Greater Boston, Janaury 12, 1981; 1981 data from internal Office of State Health Planning documents. Both papers utilized Massachusetts Rate Setting Commission Community Health Center Cost Report, Schedule B, for appropriate years.

FY 1981 REVENUE BY SOURCE AS A PERCENT OF TOTAL REVENUE FOR
INDEPENDENTLY-LICENSED COMMUNITY HEALTH CENTERS OUTSIDE BOSTON

	SUBSIDY						DIRECT PAY AND THIRD PARTY PAYMENTS				
	Federal	State	Local/ City	Private and Donated	Other	Total[1] Subsidy	Direct	Medicaid	Medicare	Private Insurance and Other	Total Direct and Third Party[1]
Lynn	47	17	4	0	1	69	4	21	1	5	31
Manet	48	0	5	2	0	55	n/a	n/a	n/a	n/a	45
North Shore	56	0	0	0	3	59	14	19	6	0	39
Revere	26	6	0	0	1	33	n/a	n/a	n/a	n/a	67

EXHIBIT 7

[1]Totals may not sum to 100 due to rounding

SOURCE: Unpublished, internal document in the Office of State Health Planning. Data gathered from Massachusetts Rate Setting Commission Community Health Center Cost Reports, Schedule B, for FY 1981.

FEDERAL FUNDING OF "SECTION 330" COMMUNITY HEALTH CENTERS FOR FEDERAL FY 1981 and FY 1982

BOSTON	1981	1982 Initial Appropriation	% Change	1982 Supplemental[1]
Brookside Park	$ 155,015	$ 38,750 (Phase Out)	-75%	--
Columbia Point	550,000	333,000	-40%	$ 25,920
Joseph M. Smith	80,000	64,870	-19%	26,000
Mattapan	117,369	97,000	-17%	30,369
Neponset	399,149	395,900	- 1%	37,886
North End	528,890	476,000	-10%	37,760
Roxbury Comprehensive	1,393,769	821,000	-41%	171,400
South Cove	472,785	405,000	-14%	55,840
TOTAL BOSTON "330" CENTERS	$3,696,977	$2,631,520	-29%	$385,175
GREATER BOSTON				
Cambridge	$ 147,284	$ Ø	-100%	--
Hull	134,000	125,840	- 6%	$ 18,960
Lynn	299,759	251,160	- 16%	41,920
Manet	66,770	68,517	+ 3%	35,840
Revere	40,187	Ø	-100%	--
TOTAL GREATER BOSTON	$ 688,000	$ 445,517	- 35%	$ 96,720
TOTAL, UWMB SERVICE AREA	$4,384,977	$3,077,037	- 30%	$481,895

EXHIBIT 8

[1]Supplemental Funds represent an additional Congressional appropriation specifically for health promotion and prevention activities, and to alleviate effects of previous budget cuts.

SOURCE: Regional Office, Public Health Service, U.S. Department of Health and Human Services, Personal Communication.

EXHIBIT 9

BUREAU OF COMMUNITY HEALTH SERVICES
ADMINISTRATIVE INIDCATORS FOR FUNDING

FACTOR	STANDARD
Physician or Team Productivity	4,200 - 6,000 encounters
Percent of Ambulatory Costs Attributable to Administration	No more than 16%
Average Cost per Medical Encounter	Between $18 - $28
Charges as a Percent of Reimbursable Costs	At least 90%
Collections as a Percent of Billings	At least 80%

SOURCE: Instruction Manual for the BCHS Common Reporting Requirements, Revised. January 1982, U.S. Department of Health and Human Services, Public Health Services Administration, Bureau of Community Health Services, Maryland.

AGGREGATE BUDGET AND MEDICAID REVENUE FOR
PRIMARY CARE FOR METROPOLITAN BOSTON COMMUNITY HEALTH CENTERS.
CALENDAR 1981 CLOSING ESTIMATES

EXHIBIT 10

BOSTON	Aggregate Budget	Medicaid Revenue	Medicaid Revenue as a Percent of Aggregate Budget
Boston Evening	$ 600,000	$ 33,000	5.5%
Bowdoin Street	380,000	130,000	34.2
Brookside Park	1,800,000	1,050,000	58.3
Bunker Hill	2,580,000	700,000	27.1
Codman Square	230,000	62,000	27.0
Columbia Point	1,000,000	300,000	30.0
Dimock	1,150,000	250,000	21.7
Dorchester House	1,300,000	350,000	26.9
East Boston	4,700,000	660,000	14.0
Fenway	450,000	11,000	2.4
Greater Roslindale	400,000	64,000	16.0
Harvard Street	2,100,000	728,000	34.7
Joseph M. Smith	700,000	40,000	5.7
Laboure Center	420,000	130,000	31.0
Little House	580,000	190,000	32.8

AGGREGATE BUDGET AND MEDICAID REVENUE FOR PRIMARY CARE FOR METROPOLITAN BOSTON COMMUNITY HEALTH CENTERS. CALENDAR 1981 CLOSING ESTIMATES (Cont...)

BOSTON (Cont...)	Aggregate Budget	Medicaid Revenue	Medicaid Revenue as a Percent of Aggregate Budget
Martha May Eliot	$ 1,400,000	$ 712,000	50.9%
Mattapan	500,000	156,000	31.2
Neponset	1,160,000	197,000	17.0
North End	1,500,000	120,000	8.0
Roxbury Comprehensive	3,000,000	700,000	23.3
Roxbury Dental and Medical Group	648,000	322,000	49.7
South Boston	800,000	230,000	28.8
South Cove	1,500,000	200,000	13.3
South End	1,250,000	1,000,000	80.0
Southern Jamaica Plain	780,000	234,000	30.0
Upham's Corner	1,400,000	540,000	38.6
Whittier Street	680,000	235,000	34.6
TOTAL BOSTON	$33,008,000	$9,344,000	28.3%
GREATER BOSTON			
Cambridge Hospital	$ 1,510,000	$ 503,000	33.3%
Chelsea	2,100,000	652,000	31.0
East Somerville	n/a	n/a	n/a

EXHIBIT 10 (continued)

AGGREGATE BUDGET AND MEDICAID REVENUE FOR PRIMARY CARE FOR METROPOLITAN BOSTON COMMUNITY HEALTH CENTERS. CALENDAR 1981 CLOSING ESTIMATES (Cont...)

GREATER BOSTON (Cont...)	Aggregate Budget	Medicaid Revenue	Medicaid Revenue as a Percent of Aggregate Budget
Foxboro	n/a	n/a	n/a
Hull	$ 350,000	$ 60,000	17.1%
Lynn	1,000,000	200,000	20.0
Manet	300,000	40,000	13.3
Mystic	n/a	n/a	n/a
North Shore	210,000	142,000	67.6
Revere	400,000	120,000	30.0
Watertown	300,000	139,000	46.3
TOTAL GREATER BOSTON	$ 6,170,000	$ 1,856,000	30.1%
TOTAL, UWMB SERVICE AREA	$39,178,000	$11,200,000	28.6%

EXHIBIT 10 (continued)

SOURCE: Massachusetts League of Community Health Centers

MEDICAID RATES PER VISIT FOR INDEPENDENTLY
LICENSED COMMUNITY HEALTH CENTERS. EFFECTIVE MARCH 1, 1982

BOSTON	Medicaid Rate
Boston Evening	$30.73
Codman Square	30.43
Columbia Point	32.86
Dorchester House	30.23
East Boston	31.11
Harvard Street	31.39
Joseph M. Smith	27.98
Mattapan	30.94
Neponset	31.98
North End	29.14
Roxbury Comprehensive	29.36
Roxbury Dental and Medical Group	32.15
South Boston	31.52
South Cove	30.78
South End	30.99
Upham's Corner	32.16
Whittier Street	31.06

EXHIBIT 11

MEDICAID RATES PER VISIT FOR INDEPENDENTLY LICENSED COMMUNITY HEALTH CENTERS. EFFECTIVE MARCH 1, 1982 (Cont...)

GREATER BOSTON	Medicaid Rate
Lynn	$32.86
Manet	27.17
North Shore	28.99
60+ Clinic	32.86

EXHIBIT 11 (continued)

SOURCE: Massachusetts Rate Setting Commission

EXHIBIT 12

UNCOLLECTIBLE BILLINGS FOR UNITED WAY-AFFILIATED
VISITING NURSE ASSOCIATIONS (VNA'S) AND HOME CARE AGENCIES

VNAs AND HOME CARE AGENCIES	ACTUAL 1981	CURRENT 1982	PROPOSED 1983
Belmont-Watertown Community Health Association	$ 1,668	$ 1,000	$ 1,000
VNA-Boston	158,932	86,057	99,660
VNA-South Shore	133,043	129,897	131,059
Cambridge VNA	45,120	39,489	28,368
VNA-Middlesex East	23,036	22,500	24,000
VNA-Greater Lynn	16,962	20,039	14,661
Malden Community Nursing Association	43,284	27,250	25,000
Medford VNA	20,296	20,000	21,250
Natick VNA	11,903	19,016	21,845
Newton-Wellesley-Weston VNA	29,008	28,759	31,633
VNA-North Shore	11,420	11,500	13,000
Quincy VNA	18,341	33,022	35,004
VNA-Greater Salem	34,921	43,410	48,000
Somerville VNA	---	---	---
Waltham VNA	2,205	8,500	3,300
VNA, Inc.	9,125	24,482	27,781
Visiting Nurse and Community Health	11,626	36,164	50,000
Homemaker-Home Health Aide Service of the North Shore	Ø	Ø	Ø
Intercommunity Homemaker Services	469	500	800
Norfolk-Bristol Home Health Services	---	24,659	30,192
North Metropolitan Homemaker Home Health Aide Service	Ø	2,000	2,000
TOTAL	$571,359	$578,244	$608,553

NOTE: Sources of "Uncollectible billings" include Medicaid, The Department of Elder Affairs, full-pay patients, insurance companies, and other.

SOURCE: ARAD Form 9, United Way 1983 Budget Requests.

EXHIBIT 13

REPORT ON A SURVEY OF METRO I UNITED WAYS AND THE FUNDING OF COMMUNITY HEALTH CENTERS

Telephone interviews were conducted with thirty-three United Way organizations serving other large metropolitan areas to explore their experiences with this type of service. It was found that 21 Metro I United Ways (63.6%) of those interviewed (33) did not fund any Community Health Centers while 12 (36.4%) did.

Table I provides an alphabetical list of the thirthy-three metropolitan areas whose United Ways were contacted and indicates which fell into these two basic categories.

The Basis of Decision--Non-Funders

Of the 21 United Ways which do not fund CHCs all but three (Columbus, Dallas and Pittsburgh) reported that the issue had never been raised in their communities.

In Pittsburgh and Dallas formal applications were made and turned down due to the large amounts of money requested and the potential for state funding or, in Pittsburgh, to the service package offered. In other Metro Ones there was considerable clustering of responses around two themes: local tradition of not supporting health programs and a local belief that CHCs were (or should be) solely the responsibility of the public sector.

The responses of representatives from all 21 United Ways, when asked why Community Health Centers were not funded, appear in Table 2.

EXHIBIT 13 (continued)

T A B L E 1

METRO ONE'S WHICH FUND OR DO NOT FUND COMMUNITY HEALTH CENTERS

METRO AREA	FUND	DO NOT FUND
ATLANTA		X
BALTIMORE		X
BUFFALO		X
CHICAGO		X
CINCINNATI		X
CLEVELAND	X	
COLUMBUS (OHIO)		X
DALLAS		X
DAYTON	X	
DENVER		X
DETROIT		X
FORT WORTH		X
HARTFORD		X
HOUSTON	X	
INDIANAPOLIS		X
LOS ANGELES	X	
MIAMI	X	
MILWAUKEE	X	
MINNEAPOLIS	X	
NEW YORK		X
PHILADELPHIA		X
PITTSBURGH		X
PORTLAND (OREGON)	X	
PROVIDENCE		X
ROCHESTER		X
SAN FRANCISCO	X	
ST. LOUIS		X
ST. PAUL		X
SAN DIEGO	X	
SANTA CLARA	X	
SEATTLE	X	
WASHINGTON		X
WILMINGTON (DELAWARE)		X

SOURCE: Telephone Survey.

EXHIBIT 13 (continued)

T A B L E 2

NON FUNDING METRO ONE'S--MAJOR REASONS FOR DECISION

METRO AREA	NO TRADITION OF HEALTH SUPPORT	PUBLIC DOMAIN	TOO MUCH MONEY	OTHER
ATLANTA	X			
BALTIMORE		X		
BUFFALO		X	X	
CHICAGO	X			
CINCINNATI				X
COLUMBUS		X		
DALLAS		X	X	
DENVER		X		
DETROIT				X
FORT WORTH	X			
HARTFORD	X			
INDIANAPOLIS		X		
NEW YORK				X
PHILADELPHIA	X			
PITTSBURGH	X			
PROVIDENCE		X		
ROCHESTER				X
ST. LOUIS	X	X		
ST. PAUL	X		X	
WASHINGTON				X
WILMINGTON	X			
TOTAL	9	8	3	5

SOURCE: Telephone Survey.

The Funders--Why They Chose To Fund

The twelve United Way organizations which currently fund Community Health Centers do so for varied reasons. Reasons were not consistent with one another. Before analyzing the major themes we will briefly list the major reasons for affiliation/funding for the nine cities from which we received detailed information. The most recent affiliations are listed first.

YEAR	CITY	REASON
1982	PORTLAND	Outside Inn, which serves a low income area close to downtown. a) Reputation for high quality medical care. b) Impact of Federal budget cuts endangering the program. c) Excellent participation as volunteers by doctors, nurses and other medical staff.
1982	SEATTLE	International District Community Health Center, which serves the Asian community, especially the Indochinese community which has grown rapidly. a) Community perception of a high level of need among Indochinese refugees for health care. b) The nature of Federal cutbacks effecting the program. c) High reputation of the agency in the Asian community.
1981	CLEVELAND	Glenville Health Association, which serves an inner city black neighborhood. a) Funding only for mental health services, which this United Way traditionally funds. b) Clear evidence for the need for additional mental health services in this geographic area. c) Agency's excellent record at attracting Federal dollars. d) Excellent agency program
1978	DAYTON	Dayton Free Clinic, no information on target population. a) Locally there is a tradition that the City of Dayton actively influences the affiliation process. The City strongly advocated for affiliation. b) Funding is limited to counseling. The Dayton United Way does not fund direct medical care.
1977	SANTA CLARA	Gardner Community Health Care Clinic, serves an isolated Mexican American community. a) United Way volunteers determined the community was medically and socially underserved. b) Santa Clara United Way has a tradition of volunters representing geogrphic areas. Volunteers representing the Gardner area advocated successfully for support.

EXHIBIT 13 (continued)

YEAR	CITY	REASON
1975	MILWAUKEE	16th Street Clinic, serves a working class black area. In Milwaukee the United Way allocates funds to specific programs rather than agencies. At present the 16th Street Clinic receives funds for a health education program, a teenage sexuality program and funds for free care for destitute families. It is likely original acceptance was on the basis of these or similar programs.
1973	MIAMI	Coconut Grove Family Clinic, serves three low income neighborhoods in Dade County. a) Community belief that the community was medically underserved. b) At the time of initial funding the Clinic was totally operated by volunteer physicians, dentist, nurses and other health professionals from the University of Miami Medical Schools. The high quality of this volunteer participation played a major role in acceptance.
1972	SAN DIEGO	Chicano Community Health Center, at the time of admission, served low income Hispanic families with a heavey emphasis on young adults. a) Heavy community pressure to "open up" the United Way to alternative programs of all kinds, not simply health care. b) Vigorous advocacy from one prominent volunteer who was an activist physician.
1970	SAN FRANCISCO	Marin County Health Center, at the time of admission, provided free health care to "street people," especially women. a) Community agreement that the population served was in great need of health care. b) Tradition within this United Way of influence by county government on the affiliation process. Marin County advocated acceptance of this agency.

Major Themes of Funders

Five United Ways (Seattle, Cleveland, Santa Clara, Miami and San Francisco) mentioned the theme of "Community Need." In some instances the "community" was defined geographically and in some instances defined in terms of a specialized population. Specific pressure from local governments for health services in a medically underserved area was also a factor.

The excellent quality of medical services was mentioned by three United Ways. The excellence of volunteer programs was mentioned by two.

The two United Ways most recently admitting Community Health Centers, Portland and Seattle, mentioned the effects of Federal budget cuts as instrumental in their decision.

Have Other Clinics Followed?

Another factor of interest is the number of health centers which were admitted subsequent to the first admission.

Table 3 shows the results. With the exception of Los Angeles, the number of Community Health Centers affiliated with United Ways is modest.

Los Angeles, which has funded such centers for a long time, has made a deliberate effort to seek out programs providing health care in the Hispanic community. San Francisco has admitted several Community Health Centers serving special populations; for example, one targets services to the elderly Asian community of Chinatown, one to women living in Berkeley and a third serving a rural community in Marin County. Other examples of such "special community" health centers are found in Milwaukee (Indians) and Santa Clara (Hispanic).

Cleveland, Dayton and Milwaukee traditionally fund specific programs within affiliated agencies rather than agencies themselves. Respondents from these cities indicated that if additional health centers applied decisions would be based on the merits of the specific programs for which support has been requested.

The other nine United Ways do not anticipate any sudden increase in applications despite the current Federal budget cuts, although some were aware of the possibility. Respondents emphasized that programs are accepted for affiliation only if a condition of great need exists within the community - defined geographically or by population characteristics - or if a particular program of great merit needs support.

EXHIBIT 13 (continued)

TABLE 3

NUMBER OF ADDITIONAL COMMUNITY HEALTH CENTERS
AFFILIATING AFTER FIRST AFFILIATION

DATE OF FIRST AFFILIATION	CITY	NUMBER OF ADDITIONAL CLINICS
1982	PORTLAND	0
1982	SEATTLE	0
1981	CLEVELAND	0
1978	DAYTON	0
1977	SANTA CLARA	1
1975	MILWAUKEE	1
1973	MIAMI	0
1972	SAN DIEGO	2
1970	SAN FRANCISCO	4
Early 60's[1]	MINNEAPOLIS	1
Pre World War II[1]	LOS ANGELES	13
1928[1]	HOUSTON	1
	TOTAL	23

[1]Refers to Health Centers providing services similar to those currently provided by Community Health Centers.

SOURCE: Telephone Survey.

Levels of Support

Table 4 displays information on the funding of the "first admitted" Community Health Center in each city. Four United Way organizations, those in Santa Clara, Los Angeles, San Francisco and San Diego, did not provide detailed financial data. -

Four of the eight reporting United Ways restrict the use of allocations to specific programs. With the exception of Milwaukee, counseling or mental health services are ordinarily the designated service.

Two United Ways provide funds to make up all of the projected deficit of their Community Health Centers. In Portland this comes to 31% of the total agency budget. In Houston the amount comes to 62% of the budget. (It is interesting to note that this agency has been a United Way affiliate for fifty four years and is administered by the Houston-Galveston Diocese of the Catholic Church).

Only Seattle and Miami provide funds for general administrative support. However, $26,000 of the Miami allocation is restricted to supporting one staff position in the X ray department.

One United Way - Milwaukee - reported that Community Health Center funds were used to underwrite "free care." (It should be noted that the Detroit United Way funds a large amount of free care provided in local hospitals.)

EXHIBIT 13 (continued)

T A B L E 4

LEVEL OF SUPPORT

CITY	AMOUNT ALLOCATED-LATEST AVAILABLE FIGURES	COMMENTS
PORTLAND	$ 28,000	Amount of projected deficit.
SEATTLE	$ 40,000	General support.
CLEVELAND	$ 55,445	Two positions in mental health.
DAYTON	$ 37,299	Counseling support only.
MILWAUKEE	$ 82,562	Health education, teenage sexuality and a fund for "free care" for destitute families.
MIAMI	$ 59,168	$33,168 - administrative. $26,000 - one staff in X-ray department and related costs.
MINNEAPOLIS	$ 50,000	$25,000 - well child. $25,000 - counseling.
HOUSTON	$361,919	Amount of projected deficit.

SOURCE: Telephone Survey and follow-up

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B. Individuals (Not including United Way volunteers or Staff)

Kenneth Brown, Public Health Service

Carla Budd, Health Planning Council of Greater Boston

David Entin, Massachusetts Rate Setting Commission

James Hooley, Dorchester House Multi-Service Center

James Hunt, Linda Lochiatto, Massachusetts League of Community Health Centers

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